Lisa Harrell Counseling Services

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: Lisa Harrell, LPCC
(name of client) 821 Raymond Avenue, Suite #440
St. Paul, MN 55114

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

☐ Information related to the scheduling of meetings or other appointments

☐ Information related to billing and payment

☐ Completed forms, including forms that may contain sensitive, confidential information

☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment

☐ My health record, in part or in whole, or summaries of material from my health record

☐ Other information. Describe: _____

If you choose to communicate with your therapist utilizing the above methods and have a need for additional safety, please discuss the options for a code communication plan with your therapist.

BY THE FOLLOWING NON-SECURE MEDIA:

☐ Unsecured email.

☐ SMS text message (i.e. traditional text messaging) or other type of "text message."

☐ Other media. Describe: _____.

TERMINATION

☐ This authorization will terminate _____ days after the date listed below.
OR

☐ This authorization will terminate when the following event occurs: _____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____
(Signature of client) Date